Exhibit B

Deposition of:

Stephen B. Levine , MD

September 10, 2021

In the Matter of:

Kadel, et al vs. Folwell

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IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

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MAXWELL KADEL, et al.,

Plaintiffs,

vs. Case No. 1:19-cv-272-LCB-LPA

DALE FOLWELL, in his official capacity as State Treasurer of North Carolina, et al.,

Defendants.

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Video Deposition of
STEPHEN B. LEVINE, M.D.

September 10, 2021
9:05 a.m.

Taken at:
Veritext Legal Solutions
1100 Superior Avenue
Cleveland, Ohio

Tracy Morse, RPR

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TRANSCRIPT INDEX

EXHIBIT CUSTODY
EXHIBITS RETAINED BY COURT REPORTER, 1-21
(No Exhibit 16)

INDEX OF EXHIBITS

INDEX OF EXHIBITS (Continued)

Q. Okay. And so then were there any external grants to research and publish about the treatment of children or adolescents --

A. No.

Q. -- with gender dysphoria?

Okay. Is that a, "No," when I included the, "Gender dysphoria," as well?

A. That is a, no.

Q. Okay. Thank you. Okay. So on page 3 of your report -- actually, I'm sorry. It's going to be the bottom of page 4 and to the top of page 5. Your report lists your experience as an expert witness, which we talked about a little bit earlier. I just -- I'm wondering if you would confirm this is not an exhaustive list of your experience as an expert witness either via deposition or report.

A. I wouldn't want to testify that this is absolutely complete, given the fact that I don't keep a list compiled. This is kind of compiled retrospectively from memory and documents. And so this is the best I could have done on April of 2021 --

Q. Understood. Thank you. So --

A. -- you might find something else.

Q. Was it --

A. -- in a commercial building where our clinic was. It was just, you know, a conference room in our clinic.

Q. And that was within -- was that within a business --

A. It was --

Q. -- a psychiatric practice?

A. I'm sorry. I interrupted you.

It was within The Center For Marital Health, which was a business that I and two other people started and owned and ran. And in that business, we continued the same kind of work we did with the University minus the large number of trainees.

Q. You mentioned that after '93, you were not being paid by the University. Were you providing your clinical psychiatric professorship gratuitously?

A. Meaning without pay? Yes.

Q. Okay. Do you know if, after you moved the clinic away from Case Western Reserve, if Case Western Reserve University Medical School created a separate gender identity clinic?

A. Years later they did --
Q. Oh, sorry.
A. -- I would say, they created a separate clinic perhaps in 2017, 2016.
Q. Do you know the name of that clinic?
A. I don't think it's in the department of psychiatry. I think it's in the department of pediatrics. And the answer to your question is, no.
Q. Does The LGBTQ and Gender Care Program sound familiar?
A. No.
Q. But have you -- sorry. Have you evaluated any patients through that separate clinic that Case Western Reserve has?
A. No. Much to my dismay, that clinic was formed and maintained without any input from me, who I thought was one of the experts in the field.
Q. Do you know if they have psychiatrists, within that clinic?
A. I -- I'm not knowledgeable about the composition of that clinic. There is a very strong liaison between our department of

What do you mean by, "This era"?

A. Before 1993.

Q. Okay. And what do you mean by, "Occasional"?

A. I would say that 95 percent of the patients that we saw were 16 and 17, 18 and up. We could debate what the word, "Child," means, but to me an 11-year-old is a child, even a 13-year-old is a child, especially when my children were 13. And so we -- in the first twenty years, transgender issues were primarily an older teenager and adult, mostly adult issues. In recent years, I would say, 12, 15 years, the number of adolescents appearing in gender clinics at our place and everywhere as far as I can see has increased exponentially, especially the number of teenage girls who are declaring themselves trans boys.

Q. So how many -- sorry. So the first twenty or so years, you said approximately 5 percent of all patients were children.

A. Were younger -- on the younger end of the spectrum --

Q. Right.

A. -- yes.

it, you see? But at this moment -- this week, I have one patient that I see weekly, who is a transgender teen. My staff -- if I can be presumptuous to call them, "My staff" -- our staff sees more.

Q. And thinking about the last year, approximately how many adult patients did you see -- and let's use your framing of, "Regular." So that could be one, for one followup visit or that could be for more -- how many adult patients did you see for treatment of gender dysphoria?

A. Approximately six.

Q. And using that same framing of, "Regular," how many children, so under age 11?

A. In the last year?

Q. Yes, yes. In the last year.

A. Zero.

Q. How many adolescents in regular treatment for gender dysphoria would you approximate you've seen in the last five years individually, exclusive of your supervision of other clinicians?

A. If you ask me the question in the last year, I would have told you five or six,

but since you ask it as a five-year period, I'm at a loss to tell you whether it's twelve or fifteen. I --

Q. An approximate is fine. Thank you.

A. -- let's just say a dozen with an asterisk, very approximate.

Q. And jumping a little bit more in terms of time. How about the last ten years?

A. Again, using the same asterisk, I would say, double it.

Q. Okay. And you said zero people under age 11, so children this last year. What about in the last five years?

A. Oh, two years ago, we had this charming little 6-year-old. One of my colleagues specializes in children and I get to hear about these cases. Occasionally I get to meet the parents, but I personally have not delivered a psychotherapeutic care or evaluation directly of a child with the exception of this one person that I was involved with.

Q. And that was this last year, you said?

A. That was -- I think it was probably

two, two and a half years ago.

Q. Oh, okay. And what kind of treatment -- I should say, have you referred any of those adolescent patients for additional treatment, besides psychotherapy, for the treatment of gender dysphoria?

A. Yes.

Q. And what kinds of treatment have you referred them for?

A. For endocrine treatment.

Q. Okay. And approximately what percentage of those adolescent patients have you referred for endocrine treatment?

A. Give me the timeframe of that question, please.

Q. Sure. So you said a few moments ago, in the last five years, you saw maybe, asterisk, 12 to 15 adolescent individually yourself. Of those 12 to 15, what would be the approximate percentage you referred for endocrine treatment?

A. I'm hesitating to answer the question, because some of those children have been taking testosterone or estrogen surreptitiously from their parents. And while

I didn't refer them for the treatment, I was seeing them while they were taking the treatment. So if we're only talking about adolescent -- referrals of adolescents for hormones, I would say a very small percentage of those, say, I guess you would say 10 percent.

Q. Fair enough. Have you had yourself individually as a clinician, have you had any non-transgender children who you have made a referral for endocrine treatments related to other conditions?

A. No.

Q. Okay. So then zooming out 30,000 foot view of your 48-year career now, would you say overall, you have provided treatment -- that is, psychiatric treatment -- to mostly adults experiencing gender dysphoria, gender identity issues?

MR. KNEPPER: Objection, form.

A. I would say that throughout my career, we should divide my career into the first twenty years where mostly adults were seen by our team and myself. And then we ought to talk about the last ten or fifteen years

where the number of adults has diminished and the number of adolescents has increased dramatically.

Q. Okay. Thank you. So as a part of your private practice, do you write letters of authorization for endocrine treatments?

A. Yes.

Q. And do you write letters of authorization for gender affirming surgeries?

A. I have. I have not recently, because most of my patients are 13 or 15 or 16, you know.

Q. Okay. And I'm sorry. Just by, "Recent," when was the last time you wrote a letter of authorization for a gender affirming surgery for an adult?

A. Probably twelve months ago.

Q. Okay. And over the course of your career focusing on your treatment of adults experiencing gender identity issues, for what percentage of those patients would you estimate you wrote a letter of authorization for gender affirming surgery for?

MR. KNEPPER: Objection, form.

A. Again, I would like to put an

asterisk to whatever I answer this question as. I have not kept track of those figures. I have written -- I've written or cosigned letters for hormone treatments and for gender confirming surgeries for many people. There were more people in the '70s and '80s than in recent decades. In part as a reflection of my own evolution of understanding of these problems and in part it's a reflection of the demography of patients who are coming to see me. I really would not like to answer that question, only because I don't know if the word, "Fifteen," or the word, "Thirty-five," is more accurate --

Q. Understood.

A. -- but I can tell you, I have written letters, especially in the early years, for the things that you're making reference to.

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(Thereupon, Deposition Exhibit 2, 12/21/2020 Zoom Deposition of Stephen B. Levine, M.D., was marked for purposes of identification.)

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Q. Okay. For the record, I'm showing

Q. Do you think as a general matter that it's good for patients who come to DELR for services related to gender dysphoria to be able to have insurance coverage of that care?

MR. KNEPPER: Objection, form. Beyond the scope.

A. Well, the people who come to DELR are generally coming for evaluation and psychotherapy services. And I believe it's very important that people have access to mental health care and that mental health care for many of our patients are not wealthy, affluent people. And the fees that even masters prepared people charge can become prohibitive. And so I think it's a very nice idea, the psychiatric services, mental health services evaluation and ongoing treatments, with or without medication, it would be nice to be able to cover those things, yes. I think that's a long answer, yes.

Q. Understood. And thinking about the treatment that you refer patients out for, the endocrine treatments in particular, do you think it is generally good if you provide authorization for that treatment that the

patient be able to afford it?

MR. KNEPPER: Objection, form.

A. May I say, of course?

Q. You may. You may say anything you would like.

A. Of course.

Q. Thank you. Well, anything you would like within reason.

If you make a letter of authorization for a patient for the treatment of gender dysphoria specifically related to a surgical treatment, do you think it is good that they be able to access that treatment that you've authorized?

MR. KNEPPER: Objection, form.

A. Not to be cagey, I want to talk about one word you just used in that sentence. I need you to understand that historically in our clinic for those 47 years, our clinics for 47 years, we are not in the business and we have never been in the business of recommending surgery or recommending hormones. We recommend a continued evaluation so that we -- the person can make up their mind how to proceed.

It is not our knowledge base to know who's going to do better and who's going to do

worse and who is not going to have any difference at all with hormones or with surgery. So what we do is we say, we will write a letter of support for endocrine treatment or for hormones if this is what you want. And we say what our concerns are. We tell the endocrinologist and we tell the surgeon what our concerns are and that we see -- we have reservations about this, and these are our reservations, but the patient has decided this is what he or she wants to do.

And so we write a letter of support, but I don't -- every time you use the word, "Recommendation," there's part of me that wants to say, no, we do not recommend. We have never recommended. We have not had the knowledge base. We have not had the clinical experience and the knowledge base to say, I'm a doctor. I know this field. This is what I recommend to make you better. We do not talk that way. We do not think that way. And so I may want to always put an asterisk to any sentence that you use the word, "Recommend." I need you to understand that that's where I'm coming from.

MR. CHARLES: Thank you,

Dr. Levine.

Excuse me just a moment. Can you read back my question. I don't recall if I used, "Recommend." I thought I used, "Authorization." I just want to make sure.

(Record was read.)

MR. CHARLES: If we could just go off the record for a second.

VIDEOGRAPHER: Off the record 10:52.

(Discussion held off the record.)

VIDEOGRAPHER: On the record 10:53.

BY MR. CHARLES:

Q. Okay. Thank you for that clarification, Dr. Levine. I'll be more careful about using terminology more close to, "Authorization," rather than, "Recommendation," and I understand your distinction in your practice. So do you, though, think it's good, if you are authorizing a treatment, a patient has said, This is the treatment I would like, and you have done an evaluation and determined that you will write, as you said, a letter of support, do you then, as a practitioner, think it's good that they can access it, that they can afford it?

concept of agency and being a doctor, I think is different than the implication of your question.

Q. Is the worrisomeness for a patient's future health, is that a reason to deny all medical care for gender dysphoria?

A. Absolutely not.

Q. Dr. Levine, I'd like to return back to, I believe it's Exhibit 2, the Claire deposition. And please, if you would turn to page 156.

A. I'm sorry. 150 what?

Q. Page 156. And beginning at line 10 on page 156, Dr. Levine, I'll read it, if you'll just follow along, please.

Question: "Are you aware that this case concerns an insurance exclusion that is categorical at preventing" --

Skipping to line 15.

"-- hormones and surgery as a treatment for gender dysphoria?"

Answer: "I am aware that your plaintiffs are suing to get coverage for -- that is not provided by their particular insurance. I am aware of that."

demonstrate their efficacy. This is the problem.

This is the essence of the problem. This is, I think the essence of my testimony with you today. It's not whether I personally as a doctor would like this patient to have insurance to cover their hormones. It's about, is this the right thing to do for this person and can I help the person see clearly what the dangers are and what the benefits are. That's the issue for a doctor, for Stephen Levine as a doctor. I hope that's a cogent answer --

Q. It is --

A. -- to your question.

Q. -- it is cogent. Thank you.

Given all of that, is that -- so you just explained, testified that there are complications, some lack of -- and I'm summarizing here, so I will confirm that this is an accurate summary of what you just shared, but I can't possibly repeat all of that. Given all of those concerns that you have, is that a reason to deny all medical interventions to people with gender dysphoria?

MR. KNEPPER: Objection, form.

A. No, but that's not -- that's a separate question about insurance.

Q. Yes, it is a separate question. So now I'm asking: Are those concerns you raised justifications in your mind for denying medical interventions to all people with gender dysphoria?

MR. KNEPPER: Objection, form.

A. You know, I'm not advocating denying endocrine treatment or surgical treatment. I'm just saying that we as a medical profession need to walk the walk that we talk. We say as a principle of ethics that our interventions should be based upon the best current knowledge, it should be based on science. It should not be based on politics. It should not be based on fashion. It should not be based on civil rights considerations. They should be based on the kinds of studies that I just described to you with predetermined outcome majors that are agreed upon --

Q. Sorry?

A. -- period.

Q. I was --

A. I forgot to put the period.

Q. That's okay. Did you just say, Dr. Levine, you're not an expert in health insurance?

A. I am not an expert in health insurance.

Q. Okay. Or what insurance should or should not cover?

A. Yes.

Q. Do you recall what the insurance billing code typically is for psychotherapy for gender dysphoria? I know it's been a long time since you've accepted commercial insurance, so I'm not sure if the billing codes are the same, but do you recall --

A. The billing code is 90837.

Q. Okay. Is there a code that you're familiar with that is F64.0?

A. That's not a billing -- that's diagnostic code --

Q. Thank you.

A. -- there's a separate code for diagnosis and a separate code for procedure.

Q. I see. So F64.0 is a diagnostic code?

A. Yes.

VIDEOGRAPHER: Off the record 11:26.

(Recess taken.)

VIDEOGRAPHER: On the record 11:31.

BY MR. CHARLES:

Q. Okay. Dr. Levine, in your report, you stated that you had not met with any of the plaintiffs in this case, correct?

A. Yes.

Q. Okay. And you have not interviewed any of the plaintiffs in this case, correct?

A. Correct.

Q. And so you are not offering any opinions about the plaintiffs in this case, correct?

A. Correct.

Q. Okay. And that would include the veracity of their experiences of gender dysphoria, correct?

A. Yes, correct.

Q. And that would not include the accuracy of their gender dysphoria diagnoses, correct?

A. Correct.

Q. Okay. You're not offering any opinions about their mental health histories?

A. Correct.

Q. Nor any of the affects of the gender affirming treatment they may have received?

A. Correct.

Q. Okay. Thank you. Let's return to your report. I don't know if you have that --

A. My report?

Q. Yes. You can put away that document in your hand.

So if you would, please, turn to page 6 of your report.

Okay. So on page 6, paragraph a. at the bottom of the page there, Dr. Levine. The report states that this is one of the opinions you're offering, which is, "Sex as defined by biology and reproductive function cannot be changed. While hormonal and surgical procedures may enable some individuals to 'pass' as the opposite gender during some or all of their lives, such procedures carry with them physical, psychological, and social risks, and no procedures can enable an individual to perform the reproductive role of the opposite sex." Did I read that correctly?

methodology and are capable of critically reviewing the literature. So your statement is true on the most superficial level, but is totally incorrect when it comes to scientific standards of care for issuing guidelines for the medical profession. So I don't know how to answer the question. On the surface, the answer is, yes. And underneath the surface, the answer is, no.

Q. So the International Journal For Transgender Health is still a peer-reviewed source, though, right?

A. It's peer reviewed by people who make their living supporting transgender care.

Q. But it's still peer reviewed, right?

A. It's peer reviewed --

Q. And as for your --

A. -- I think it's peer reviewed.

Q. Okay. Understood. And as for your more conservative approach, can you cite to any studies or research that resulted in better outcomes than people who adhere strictly to the WPATH standards of care version 7?

A. No. This is part of the problem in

evaluation leading to a therapeutic process, it seems prudent, given the fact that we are changing people's bodies, especially teenagers' bodies, and they are not of developmental sophistication yet that court systems or at least one court system thinks they're certainly too young to make these life-altering decisions. So people in SEGM are biased in the direction of being conservative and providing psychotherapeutic evaluations of the child, of the teenager and of their parents, of their family systems to see if we can find a way to help them be informed about what is going -- what they think they want to do in their future.

Q. And so when you provide letters of authorization for hormones or for surgery, do you do so in accordance with the WPATH standards of care?

A. Yes. That is the standard, to provide a letter of recommendation.

Q. Okay. So turning back to your report, Dr. Levine. You can go ahead and put away the trial transcript there.

A. I'm sorry. Did you say, "Turning

Q. Okay. So is a, "Hypothesis," an idea about why something happens, but doesn't provide evidence for why something is happening?

MR. KNEPPER: Objection, form.

A. A, "Hypothesis," generates the pursuit of evidence.

Q. Has social contagion as an explanation for increased cases of gender dysphoria been scientifically proven yet?

A. No. But when you seek -- when you see -- actually see patients and talk to them about their friends and hear about the influence of the Internet and the gurus on the Internet who tell 13 and 12-year-old children who are concerned about menses or concerned about breast development or concerned about their bodies changing and then they're told that they're transsexual by somebody that they've never met that they talked to on the Internet, that would be social contagion or social education.

Or when you hear about a friend who declares themselves trans and then your patient six months later declares themselves trans, you

wonder about the -- the interpersonal, psychological link between best friends in young puberty, young years of puberty and how one can identify with one's friends and that would be a social contagion. Those are 3the kinds of ideas that people like me get when we sit with people week after week talking about their lives. You see, that's not science.

But that is clinician and this is the kind of thing that leads to intuition, clinical intuition and that's the source of the generation of the hypothesis. But we think as clinicians, when we hear -- I mean, I don't think I've ever seen a teenager trans person who hasn't been heavily involved and influenced by the Internet, for example, but I have not done studies to document that in a way that would be scientifically acceptable. There are other people who have.

And I doubt very much if you'll ever find a clinician on any side of this issue, you see, who would say, oh, no most of my patients have never talked to anyone on the Internet about transgender. The Internet is just part of life today and -- but transgender teenagers spend

hours and hours of their time getting counseled or participating with the virtual trans community. That's a hypothesis.

Q. So no scientific citation?

A. When we use the word, "Scientific," in the best sense, yes, the answer to your question is, no scientific.

Q. Okay. No studies of citations you can point to today to support that hypothesis?

A. Oh, I think Lisa Littman's studies are in the literature and/or in press that documents this.

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(Thereupon, Deposition Exhibit 7, "Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria," Article, was marked for purposes of identification.)

- - - - -

Q. Okay. For the record, please note I'm showing to Dr. Levine what has been marked as Exhibit 7. "Correction: Parent reports of adolescents and young adults perceived to show

signs of a rapid onset of gender dysphoria," by Lisa Littman published March 19, 2019. Have you seen this material before, Dr. Levine?

A. I've seen of it. I don't think I've read it.

Q. Okay. Were you aware that the Lisa Littman article had to be withdrawn, corrected and republished?

A. Yes.

Q. Okay. And were you aware that the initial article was based on a survey of parents --

A. Yes.

Q. -- of purportedly transgender children and the parents were recorded -- I'm sorry. Let me start over. Were you aware that the Littman article was based on a survey of parents who were recruited through some parent groups?

MR. KNEPPER: Objection, form.

A. I knew it was a survey of parents.

Q. Okay. And did you know there were no report-outs from the young adults of those parents in the article?

A. It was a report of parents'

transitioning. However, it is...important to note that there are other survey items where the parent would have direct access to information about their child and that those answers reflect items that can be directly observed." Did I read that correctly?

A. Yes, you did.

Q. All right. Your report also cites as support for the social contagion hypothesis to an article from Medscape.com written by Becky Mccall and Lisa Nainggolan as support for the social contagion theory. Is that correct? I'm sorry. It's not going to be on this article, Doctor.

A. I don't know that article.

Q. Okay.

A. You haven't asked me a question about this. Did I misunderstand something?

Q. No, no. Sorry. We're just --

A. You haven't asked my opinions about that, yeah.

- - - - -

(Thereupon, Deposition Exhibit 8, "Transgender Teens: Is the Tide Starting To Turn?" Article, was

marked for purposes of identification.)

- - - - -

Q. Yeah. So, for the record, I'm showing Dr. Levine what has been marked as Exhibit 8. "Transgender Teens: Is the Tide Starting To Turn?" by Becky McCall and Lisa Nainggolan, April 26, 2021. Dr. Levine, you said you have not reviewed this article before?

A. Which one are you referring to?

Q. I'm sorry. That one to your left.

A. This?

Q. Yes. Take your time.

A. Have I reviewed it, no. You know, I've seen the picture of Keira Bell. I've seen news reports of this in the past, but they were just news reports, yeah.

Q. Do you know if either of the authors of this article is a scientist?

A. I have no idea.

Q. Okay. Or a psychiatrist?

A. (Indicating.)

Q. I'm sorry. Could you make your responses verbal? I'm forgetting.

A. I have no idea.

Q. Okay. Thank you. Have either of them ever treated transgender children or adolescents?

A. I would have no idea.

Q. Okay. To your knowledge, is the information provided on Medscape.CA subject to peer review?

A. I don't know how Medscape works. I've heard there have been retractions, but I don't know how their peer reviewed is made. Perhaps people write in that, This is ridiculous what you've been teaching or what you've been saying, but whether they're peer reviewed or not, I have no idea.

Q. So you probably -- I'm sorry. So do you know if this article has been published in a peer-reviewed journal to your knowledge?

A. "Transgender teens: Is the Tides" -- that article?

Q. Yes.

A. I don't know. I don't know this article. I don't know where it's from.

Q. Okay. So your report includes a quotation from this article. "The vast majority of youth now presenting with gender

multi-continental set of observations from Europe, from Australia, from North America --

Q. Okay.

A. -- it almost doesn't even need citations it's so clinically apparent.

Q. Okay. But there's no citation in your report?

A. In my report, yes.

Q. Okay. So on page 18, going back to your report, at the bottom of page 18, you use a term, "Transgender Treatment Industry." Is this the first time you have used this term?

A. In this report?

Q. No.

A. You mean, did I ever use it in another report?

Q. Yeah, yeah.

A. I'm not sure. If this is -- if it's not the first, it might be the second.

Q. And where did the term originate?

A. I think it -- the term originated from Dwight Eisenhower at the end of his -- when he was leaving the presidency in 1952, he warned the people about the military industrial complex and that there was a very comfortable

the methods we made reference to before, the efficacy of the treatment and the downsides of the treatment. But because WPATH is an advocacy organization and the scientific establishment of the efficacy of their treatments are not important to them, what they are doing is teaching young mental health professionals and medical professionals as a whole what their ideology is. They say it's scientifically established.

I'm here to tell you to the extent that I understand science, it is not scientifically established. In a sense, there is an industry that has different elements that feed each other; that's the transgender treatment industry. I think if we put our heads together, we could find another term.

Q. So did you coin that phrase then?

A. No --

Q. Okay.

A. -- no.

Q. Have you seen it used before in any peer-reviewed articles?

A. Not in a peer-reviewed article. I've seen it used in these kind of expert

opinion -- (Indicating.)

Q. Okay.

A. -- I would -- you know, if I had time and I had a committee of people, I -- I would probably find a different term for it. But I don't mean it in a disparaging way. I mean that this is a group of compassionate people trying to help other people who actually believe that the science has established the best practices when in fact they're not well informed.

Q. Do you need a sip of water after that?

A. No. I'm just a long-winded guy.

I want to add, if I may, that we should make a distinction between education and indoctrination. Education can be based on science. Indoctrination is based on preferred beliefs that, if you allow me to use this term again. The transgender treatment industry is heavy on indoctrination and has declared, if you look at the standards of care, if you don't believe these systems, you're not a competent -- you're not competent to take care of people. That of course is the height of

A. No. Their gender dysphoria may be a product, you see, of these other things. For example, if you have someone who has been sexually abused by her stepfather and becomes a trans person in adolescents, we want to talk about the sexual abuse and the process between that person and what fears for the present and the future that has caused the child. And we're not attacking their trans identity. We're trying to help them understand where they came from and what they're coping with and why they're so fearful or so distressed by their body changing.

Q. And their gender dysphoria could be separate and apart from that traumatic experience?

A. Theoretically it could be, yes.

Q. And if it persisted sufficiently enough, you would consider a letter of authorization for --

A. Yes.

Q. -- hormones?

A. Yes.

MR. KNEPPER: Objection, form.

Q. Okay. If you would, please, turn

A. That is correct. And may I add that it's very, very difficult to understand. The natural question would be, how do you compare the general population with the trans people who did not have surgery with the trans people who did have surgery.

Q. Thank you, Dr. Levine. That's not my question, though. I just wanted to confirm that was not the control group. You mentioned this study later in your report, page 66 beginning at paragraph 74. Do you see that?

A. Um-hum.

Q. Okay. And basically that -- well, here, let me point you exactly. The sentence starts with, "Similarly," about halfway down the page, third sentence of that paragraph.

A. Um-hum.

Q. And, as you mentioned, you cite the Dhejne study and I believe -- or I should ask: Is the Denmark study you're referencing the study directly after it --

A. The Simonsen study.

Q. -- the Simonsen study?

A. Yes.

Q. Okay. So beginning with the Dhejne

study, do you think because that study showed that some people committed suicide after gender affirming surgery that no patient should be able to access gender affirming surgery?

MR. KNEPPER: Objection, form.

A. That would be illogical.

Q. Okay. Dr. Levine, I understand you said that would be illogical, but just to be clear. You're not recommending -- sorry. I'm not using that word. You're not saying that the fact that some people commit suicide following gender affirming surgery means that there should be a ban on access to that surgery. Is that right?

A. Not for that reason, no.

MR. KNEPPER: Objection, form.

Q. Not for that reason. Okay. Are you recommending that there would be bans on gender affirming surgery for any reason?

A. I think there are -- you know, I think most prudent people in this field, just to use the example of what you read out loud about the Finland study, a case-by-case basis. That's how doctor need to decide things, but there are many, many reasons to be cautious

fashion and to be very hesitant about going forward.

Q. But you're not recommending total bans on gender affirming surgery?

A. I'm not recommending total bans. I'm aware of the individual circumstances of individual people's lives and their commitment to transgender living. And I don't want to be draconian about this. I want to be compassionate about this.

Q. I understand. I appreciate that. I just want to make sure I'm understanding you correctly.

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(Thereupon, Deposition Exhibit 12, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," Article, was marked for purposes of identification.)

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Q. So for the record, I'm presenting to Dr. Levine what has been marked as Exhibit 12. "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment

For the 22nd time today, did I read that correctly?

A. It's the 23rd time.

Q. Oh, okay.

A. Yes.

Q. I was hoping you weren't counting, but, okay. Did you testify earlier today that the limitation of the Dhejne study is that the controls were not transgender persons who had not undergone gender affirming surgery?

A. Yes.

MR. KNEPPER: Objection, form.

Q. Okay. You can set that aside, Dr. Levine.

- - - - -

(Thereupon, Deposition Exhibit 13, 2017 "On Gender Dysphoria," Booklet From Department of Clinical Neuroscience, Karolinska Institutet, Stockholm, Sweden, was marked for purposes of identification.)

- - - - -

Q. For the record, Dr. Levine has an exhibit that has been marked as Exhibit 13. "On Gender Dysphoria," by Cecilia Dhejne from

ideation in transgender people.

A. Well, you know about the Branstrom-Pachankis study and the criticism of the study --

Q. But I'm not talking about the study.

A. -- and part of the study demonstrated that it increased suicidal ideation and attempts in the first two and a half years after surgery, especially in the first year --

Q. Right. Is your testimony --

A. -- so I'm not testifying that. I thought you were asking me about this, which I need to comment on, because this is not an accurate depiction of my statement in the reference. (Indicating.)

Q. Well, that's not what I'm asking about, Dr. Levine.

A. Well, you're reading this and I'm misquoted here. So I don't want you to imply that she is accurately representing my views, because I did not say that gender affirming treatment in general should be stopped. I've never said that. This is an article about

at different times have reported that in the large majority of patients, absent a substantial intervention such as social transition and/or hormone therapy, gender dysphoria does not," continue, "through puberty."

So there are some children who persist in their asserted gender identity through puberty, correct?

MR. KNEPPER: Objection, form.

A. Correct.

Q. And some who persist in wanting to transition via medical treatments?

MR. KNEPPER: Objection, form.

A. Yes. Some of the children have learned about medical treatments somewhere along the line and they feel instantly that this is for them.

Q. And then looking at paragraph 56, which is on page 41, so just the very next page on the bottom, the second sentence in that paragraph. "I observe an increasingly vocal online community of young women who have reclaimed a female identity after claiming a male...identity at some point during their teen

transgender people is individual based, right?

A. Well, it's both --

MR. KNEPPER: Objection, form.

A. -- yes, that's partially true. And ideally that's true, but it's obviously not entirely true. It's why we're here, is it's categorically based.

Q. Let me rephrase that. You design treatment for your patients based on what that patient in front of you, what they need, what they want, what you determine -- sorry. Not what you determine, but what you might authorize?

MR. KNEPPER: Objection, form.

A. What the patient and I discern together.

Q. Thank you. Okay. Let's jump to, again, still in your report, page 68.

A. We've left 40 and 41? 68.

Q. Okay. Looking at the bottom of page 68, Dr. Levine, paragraph 78. It states, "Similarly, the American Psychological Association has stated because approach" --

A. Sorry.

Q. I apologize.

Gender Nonconforming People (2015)."

So is that lack of consensus that you discuss a justification to categorically ban social transition for children as a treatment for gender dysphoria?

MR. KNEPPER: Objection, form.

A. By, "Children," you mean 6 and 7 year olds?

Q. Those for whom medical intervention is not indicated.

A. Is that a reason to ban it?

Q. Correct, social transition.

MR. KNEPPER: Objection, form.

A. The reason to -- so let me qualify that. There's a, yes, answer, there's a reason to ban it. And the reason to ban it is both a developmental and an ethical reason. There have been eleven studies of these cross-gender identity children who are not socially transitioned and the vast majority of them de-transition by the time they're mid adolescents or older adolescents. They become homosexual individuals usually or bisexual individuals, but they are cis gender.

So if we take a 6-year-old child and

A. -- nor you didn't ask me to comment on that.

Q. It was related to what you had said before. So this is related but not related to what we just read. So you can put that aside.

A. Okay. But your next question was about puberty blocking hormones, which are not being used for 6-year-old's and 7-year-old's --

Q. Correct, yes, a separate group of people.

A. -- so we're on a different category.

Q. Yes.

A. Okay. So you asked me if I think puberty blocking hormones should be used on a case-by-case basis?

Q. Correct, yes.

A. I don't think so.

Q. So that is to say, there are no circumstances you would advocate for a total ban on that intervention?

MR. KNEPPER: Objection, form.

A. Number one, I've never seen a child where that has come up where I thought it was a good idea. In the cases I've seen, it was like

a treatment for the mother's pathology, not for the child. And it's like a warning sign, boy, be careful. You see, if you see one case like that, you wonder -- and it's so conspicuous, you wonder in the next case, if the same thing is going on in a more subtle way.

Is the child acting out the ambitions of the mother or the father? I just think prudence -- I think considering the child has not gone through puberty or has not gone far into puberty and puberty brings all kind of psychological, physical and social changes to a child and those changes lead to desistance in many, many children, to put them into a state where all their peers are developing physically and they're going to be poirot (phonetic).

And then most of those children have social anxiety problems and they avoid -- they don't have friends, right. And this is going to make them even more different than their peers and it's gone to deprive them of the sexualization of their mind and the discovery of masturbation and the discovery of sexual desire for partners, you see. This is only going to increase the child's difference from

her peers or his peers and I don't think this is a prudent idea.

And if you wanted me to suggest a ban on anything, it would be a ban on using puberty blocking hormones, especially when the evaluation of those children are focused on the gender dysphoria of the child and not on the background of the child and not on what's going on. So I think that's an answer to your question.

If we're going to use these drugs, if we're going to use social transformation of children, if we're going to use puberty blocking hormones, it should only be used in a carefully designed protocol. And follow up has to be guaranteed so in one year and in two years and in three years and before we start giving cross-gender hormones we have data --

Q. Sorry.

A. -- so the answer to your question is, I would consider banning puberty blocking hormones even for children who have been cross-gender identified for four years to give them a chance to desist, which is exactly what the Dutch protocol did, by the way.

Q. Sorry. So you just said you would ban -- you would recommend a ban on --

A. If --

MR. KNEPPER: Objection, form.

A. -- look, I'm a doctor. I'm not a policy maker --

Q. I understand, yes.

A. -- if you ask me my political opinion about, should we ban this, is that a reasonable thing, I think there's a very strong argument for banning puberty blocking hormones.

Q. Okay. And, right. So you're here as an expert offering an expert opinion. So are you separating that from -- like are you saying your political views that you would advocate for bans or are you saying your expert opinion you're offering in this case is you would recommend ban?

MR. KNEPPER: Objection, form.

A. I would recommend ban. To what extent it's from my politics or from my being a parent or from my being a doctor, I don't know. I would recommend we not use puberty blocking hormones.

Q. In Claire, in this case that we

Answer: "Where we had a healthy mother and father, an intact family who was psychologically informed and who has -- where a child has come out of toddlerhood acting consistently in a gender atypical fashion, and where the parents are not homophobic..."

Question: "The parents are not what kind of people?"

Answer: "Homophobic."

For the 27th time, did I read that correctly? Did I read that correctly?

A. Yes.

MR. CHARLES: Okay. All right. Let's go ahead and take a break for a few minutes.

VIDEOGRAPHER: Off the record 3:20.

(Recess taken.)

VIDEOGRAPHER: On the record 3:38.

BY MR. CHARLES:

Q. So, Dr. Levine, before the break, you were talking about 6 and 7 year olds and you mentioned there were eleven studies. Can you identify which eleven studies from your report you're referring to?

A. Cantor, the reference Cantor lists

the eleven studies and these eleven studies have been done over probably thirty years.

Q. Okay. So Cantor was one review of eleven studies?

A. Cantor was a review of the eleven studies. I can't list to you the eleven individual studies. The latest one is written by Singh, S-i-n-g-h. It was published in April of 2021, in the Frontiers of Psychiatry. And that perhaps is the most comprehensive of them. And that's the one that confirms -- that's a study of boys and it confirmed that 12.2, I think percentage of them persisted over a thirteen-year period.

Q. So that was one -- that was the Singh study that came out. Is that same study mentioned in the Cantor review?

A. (Nodding.)

Q. Okay. And you said that established that 12.2 percent of prepubertal boys persisted into adolescents? Okay.

A. Yes. This harkens back to the ethical issue that I talked about before. You know, if you know that 88 percent of them are going to persist -- desist, why in the world

identified 60,000 case reports world wide on the Internet. See Exposito-Campos..." --

A. That is an error, by the way.

Q. Sorry. Which part of that is an error?

A. That, "60,000," is my error. It should say, "16,000."

- - - - -

(Thereupon, Deposition Exhibit 17, "A Typology of Gender Detransition and Its Implications for Healthcare Providers," Article, was marked for purposes of identification.)

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Q. Okay. So for the record, I'm showing Dr. Levine what has been marked as Exhibit 17. "A Typology of Gender Detransition and Its Implications for Healthcare Providers," Pablo Exposito-Campos, 2021. Okay. Have you seen this study before, Dr. Levine?

A. Yes.

Q. Okay. So on page 1 of this report, about halfway through the very first paragraph in the introduction beginning with, "As a consequence." Do you see that there?

important to note that this typology does not suggest two clear-cut categories, for a secondary detransition can lead to a primary detransition" -- oh, sorry. Let me start over. Sorry.

Okay. Let me start from a different place, Dr. Levine. The second sentence. "In r/detrans" --

And there's an HTTP address --

A. Okay.

Q. Okay. You see that.

-- "a subreddit for detransitioners to share their experiences with more than 16,000 members, one can find several stories of people who call their transgender status into question after stopping transitioning due to medical complications or feeling dissatisfied with their treatment results"?

Do you know what a, "Subreddit," is, Dr. Levine?

A. I believe it's just a division of a larger website where people, you know, with similar interests.

Q. Okay. Do you understand this sentence to be suggesting that all 16,000 of

those members have offered a story of detransition?

MR. KNEPPER: Objection, form.

A. I think -- I think it may be true that either they have offered a personal story or they're fascinated because of their own considerations of that story. They're thinking about it themselves, which would be in keeping with the idea that even people who have transitioned begin to doubt whether they made a wise decision and they're considering detransition. I'm not so sure it means that all 16,000. I would have no way of ascertaining that. You know, in my worry, I would lean towards most of them are seriously considering or have detransitioned. And in my skepticism, I would say I'm not sure whether it's 15,000 or 12,000 or 8,000.

Q. But you have no way to confirm that --

A. I have no way.

Q. -- if it's all of them or a few of them or three of them?

A. You're absolutely right. I have no way of confirming that.

where hormones are safe and surgery is a good thing to do. If a person said that, you know, skeptically, I think that would disappoint certain patients, but how it was said and when it was said in response to what would either determine whether the person is engaged with the mental health professional or leaves the mental health professional. You know, all mental health professionals are not created equal.

Q. So it sounds like you're saying it could do harm to that patient?

MR. KNEPPER: Objection, form.

A. No, I'm not saying that. I'm saying it could be disappointing to that person. What that person did with the disappointment may prove harmful just because of that person or it may prove in fact beneficial.

Q. Are you satisfied -- let's orient this question around the patients you've seen in the last 12 months. Are you satisfied that those patients -- actually, sorry. Let me start over. Are you satisfied that the patients you have seen historically for whom

you provide letters of authorization for hormones give sufficiently informed consent?

MR. KNEPPER: Objection, form.

A. From my point of view, I did what I could to reach the standard of having the person internalize and think about, digest, dream about and come back and talk to me about it. That's all I can do. I can't guarantee that if I do what I do that it's going to change your mind or help you steer your ship in a slightly different angle --

Q. So --

A. -- so I would not write a letter of recommendation if I didn't feel like I did my part. And if the person indicated that they couldn't pay attention to me, I wouldn't write the letter.

MR. CHARLES: Understood.

Okay. John, finished.

MR. KNEPPER: You're finished?

MR. CHARLES: I mean, barring --

MR. KNEPPER: Barring --

MR. CHARLES: We can't tell the future.

MR. KNEPPER: I wasn't ready for

history and current psychiatric diagnosis, it's more complicated than just the internet.

But we need to understand who these children are and how they're different from their peers and what we could possibly do to help them to have a better life. I know some of the conversation today was, we'll help them have a better life by giving them puberty blocking hormones, but that doesn't address -- I think it has a risk of harming them further. And it doesn't address the comorbid developmental challenges that these children face.

And I'm afraid -- and it's controversial, because I don't have the answer. I'm afraid there's a possibility we're making these children have a worse outcome. And until you can demonstrate to me in a very careful controlled study that separates the autistic from the non-autistic, you see? That separates the kids who come from a family that's intact from a family where there's a single parent. Where you can separate the kids who were sexually abused from the kids who were not sexually abused. I'm not sure puberty blocking